AGING AND DISABILITY SERVICES ADMINISTRATION
OMNIBUS BUDGET RECONCILIATION ACT (OBRA)
NURSING ASSISTANT TRAINING PROGRAM
PO BOX 45600
OLYMPIA WA 98504-5600

DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION
PO BOX 47864
OLYMPIA WA 98504-7864

APPLICATION FOR NURSING ASSISTANT TRAINING PROGRAM DIRECTOR (NATCEP)

1. NAME			HOME TELEPHONE NUMBER (INCLUDE AREA CODE ( )
HOME ADDRESS			2. REGISTERED NURSE LICENSE NUMBER
CITY	STATE ZIP CODE	EXPIRATION DATE	E-MAIL ADDRESS

3. Is your Registered Nurse (RN) license number encumbered or otherwise limited due to disciplinary or other action?
☐ Yes ☐ No
If yes, describe the action below.

4. NAME OF FACILITY OR INSTITUTION WHERE APPLICANT SERVES (OR WILL SERVE) AS PROGRAM DIRECTOR		TELEPHONE NUMBER (INCLUDE AREA CODE ( )
ADDRESS	CITY	STATE ZIP CODE

5. What is your present position at this facility or institution?

6. How many years have you activity practiced nursing as an RN?

7. How many years listed in Question 6 above were in the provision of long-term care facility services and how many years in direct patient care?
Describe these services below.

8. Have you completed the required "Train the Trainer" program or equivalent? ☐ Yes ☐ No
If yes, briefly describe the class and if possible, attach a copy of the course documentation.

9. If the answer to Question 8 above is no, please describe your experience teaching adult courses over and above in-service education or patient teaching. Attach separate sheet if necessary.

10. Will the program director also serve as the course instructor? ☐ Yes ☐ No
If yes, will your primary teaching responsibility include: ☐ Classroom ☐ Clinical ☐ Both

DECLARATION

IMPORTANT: I declare that the information I have written above is factual. I have read and understand the responsibilities of a program director for an approved Nursing Assistant training program and will assure that the standards for an approved program are followed. I also agree to notify the Department of Social and Health Services (DSHS) and the Department of Health (DOH) within 72 hours of my leaving my job as Program Director. I further understand that I must notify both DOH and DSHS at the address provided above whenever significant changes occur in the training program for which I am Program Director.

SIGNATURE OF APPLICANT	DATE